Summary of Benefits

SINGLE PLAN OPTION

	IN-NETWORK	OUT-OF-NETWORK
MAJOR MEDICAL		
Deductible (Ded)	$500/Individual $1,500/Family	$1,000/Individual $3,000/Family
Coinsurance Percent (MM)	100%	60%
Out-of-Pocket Maximum (Includes Deductible)	None None	$5,000/Individual $15,000/Family
Lifetime Maximum per Family Member	$2,000,000	$2,000,000
WELLNESS (Routine Care)		
Pap smears & Mammograms	$25 Copay then 100%	60% after Deductible
Well-child care, immunizations	$25 Copay then 100%	60% after Deductible (ded waived through age 5)
All other Routine Care services (includes adult physical exams & cancer screenings)	$25 Copay then 100%	60% after Deductible
PHYSICIANS OFFICE VISITS	$25 Copay then 100%	60% after Deductible
URGENT CARE	$60 Copay then 100%	$60 Copay then 60% after Deductible
HOSPITAL BENEFITS		
In-Patient	100% after Deductible	60% after Deductible
Out-Patient	$100 Copay then 100%	60% after Deductible
Emergency Room	$100 Copay then 100% Copay waived if admitted Medical emergency only	$100 Copay then 100% Copay waived if admitted Medical emergency only
SURGICAL BENEFITS		
In-Patient Out-Patient	100% after Deductible $100 Copay then 100%	60% after Deductible 60% after Deductible
DIAGNOSTIC X-RAY & LABORATORY SERVICES	100% after Deductible	60% after Deductible
THERAPY SERVICES		
Speech Therapy	$25 Copay then 100% 20 visit Cal. Yr. Max.	60% after Deductible 20 visit Cal. Yr. Max.
Physical, Occupational Therapy	$25 Copay then 100% 20 visit Cal. Yr. Max	60% after Deductible 20 visit Cal. Yr. Max
Respiratory Therapy	100% after Deductible 30 visit Cal. Yr. Max	60% after Deductible 30 visit Cal. Yr. Max
Radiation Therapy, Chemotherapy	100% after Deductible	60% after Deductible
MENTAL/NERVOUS & SUBSTANCE ABUSE		
In-Patient	100% after Deductible	60% after Deductible
Out-Patient	$25 Copay then 100%	60% after Deductible
ADDITIONAL MEDICAL BENEFITS		
Home Health Care	100% after Deductible 120 Visit Cal. Yr. Max.	60% after Deductible 120 Visit Cal. Yr. Max.
Extended Care Facility	100% after Deductible 30 Day Cal. Yr. Max.	60% after Deductible 30 Day Cal. Yr. Max.
Hospice	100% not subject to Deductible $10,000 Lifetime Max	100% not subject to Deductible $10,000 Lifetime Max
Chiropractic Services	$25 Copay then 100% 20 visit Cal. Yr. Max.	60% after Deductible 20 visit Cal. Yr. Max.
Ambulance Services	100% not subject to Deductible	100% not subject to Deductible
Medical Supplies and Durable Equipment	100% after Deductible	60% after Deductible
PRESCRIPTION DRUG CARD		
Retail (30 day supply)	$15 Generic/$30 Preferred $60 Non Preferred	60% after Deductible 60% after Deductible
Retail (90 day supply)	$30 Generic/$60 Preferred $120 Non Preferred	60% after Deductible 60% after Deductible
Mail Order (90 day supply)	$30 Generic/$60 Preferred No coverage for Non Preferred	Not covered Not covered